OPINIONS OF THE STAFF AND USERS ABOUT THE QUALITY OF THE MENTAL HEALTH CARE DELIVERED AT A FAMILY HEALTH PROGRAM

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Authors aimed at learning about the mental health care provided at a Family Health Program. 142 subjects were interviewed (18 nurses, 78 agents, 17 patients and 29 family members). In order to collect data, authors used the Scale of Opinion on Mental Health Care with 25 statements on the care, orientation by the members of the Program of Family Health team and the benefits of this Program. The total scores showed a difference between the agents and other groups. Among nurses, they found the shorter deviation and among the patients the greater variability in the responses. They emphasize the need for efficacy in arranging the appointments. Authors found a lack of coherence among the opinions of the subjects regarding the professionals' orientations.

DESCRIPTORS: family health program; psychiatric nursing; scales

OPINIONES DEL EQUIPO Y USUARIOS SOBRE LA ATENCIÓN A LA SALUD MENTAL EN UN PROGRAMA DE SALUD DE LA FAMÍLIA

El presente trabajo tuvo como objetivo conocer la atención a la salud mental en un Programa de Salud de la Família. Fueron entrevistados 142 sujetos (18 enfermeras, 78 agentes, 17 pacientes y 29 familiares). Para la colecta de datos se utilizó la Escala de Opinión sobre Atención a la Salud Mental con 25 afirmaciones sobre asistencia, orientación del equipo del PSF y benefícios de este Programa. Los escores totales demostraron mayor diferencia entre los agentes y demás grupos. Entre las enfermeras se encontraró el menor desvio y entre los pacientes la mayor variabilidad en las respuestas. Destaque mayor para la eficaz manera de marcar las consultas. Hubieron evidencias de incoerencia entre las opiniones de los sujetos cuanto a las orientaciones de los profesionales.

DESCRIPTORES: programa salud de la familia; enfermería psiquiátrica; escalas

OPINIÕES DA EQUIPE E USUÁRIOS SOBRE A ATENÇÃO À SAÚDE MENTAL NUM PROGRAMA DE SAÚDE DA FAMÍLIA

Objetivou-se conhecer a atenção à saúde mental num Programa de Saúde da Família (PSF). Foram entrevistados 142 sujeitos (18 enfermeiras, 78 agentes, 17 pacientes e 29 familiares). Na coleta de dados, utilizou-se a Escala de Opinião sobre Atenção à Saúde Mental, com 25 afirmativas sobre assistência, orientação da equipe do PSF e benefícios desse Programa. Os escores totais demonstraram maior diferença entre os agentes e demais grupos. Entre as enfermeiras encontra-se o menor desvio e entre os pacientes a maior variabilidade nas respostas. Destaca-se maior eficácia no agendamento das consultas. Evidenciou-se incoerência entre opiniões dos sujeitos quanto às orientações dos profissionais.

DESCRITORES: programa saúde da família; enfermagem psiquiátrica; escalas

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INTRODUCTION

Despite influence from psychiatric reform principles, the asylum care system still persists in Brazil.

The gradual implantation of ethical and responsible psychiatry aims to promote mental health, identify and give adequate treatment to cases of disease and take care of chronically-ill patients' rehabilitation, using new devices (day hospital, hospitalization in a general hospital, outpatient clinic, Psychosocial Care Center - CAPS, Psychosocial Care Group - NAPS, pensions) and competent professionals who identify with this new proposal.

These contrasts reveal that many decades have passed for the reform movement to become a reality and be part of the new health system, adopting preventivist conceptions, substituting asylum by open treatment, stimulating the offering of ethical care in respect of patients with psychiatric disorders. As a result, budgets of the Health Ministry and Brazilian cities have been distributed differently.

Nowadays, the presence of mental patients at home is a reality, whether due to criteria that make random hospitalizations more difficult or due to the existence of outpatient clinics, NAPS and CAPS, which allow for treatment without unnecessary hospitalizations. Moreover, treatments using more efficient drugs with less collateral effects facilitate patients' adherence to treatment and social insertion.

However, how have relatives been living at home with mental patients who are no longer confined to mental institutions?

Koga and Furegato examined how schizophrenic patients live with their relatives and concluded that relatives live with an overload in terms of finance as well as domestic routine and physical and/or emotional disease. This study was replicated and found various factors of overload that entailed alterations in personal life and in family and social interactions[1]. Another study[2] evidenced that relatives adapt and reorganize themselves to welcome the ill person and minimize damage.

Besides the positive reflexes of the psychiatric reform[3], we are now faced with another favorable situation, which is the creation of Family Health Programs (FHP).

The municipalization of health management and social control encourages the expansion of extra hospital actions and prioritizes the organization of practices aimed at care delivery to families in their social space, as a health care focus, including differentiated and guaranteed financial transfers, through the adoption of the Community Health Agent Program – CHAP and FHP in Brazilian cities[4].

Basic FHP units should be able to solve 85% of health problems in their community, delivering quality care, preventing diseases, avoiding unnecessary hospitalizations and improving the population's quality of life.

As teachers, we are facing various confrontations with reality, that is, once again, practice provides us with plenty of teaching material and, from teaching, we return to practice with experience and criticism. Training centers affiliated with colleges outline this objective, which stimulates discussions. In discourse, attempts are made to eliminate the dichotomy between mind and body.

The implantation of the FHP in Maringá, with 57 family health teams working at 24 Basic Health Units, makes us question whether mental patients and their relatives have been receiving some type of care or guidance after the implantation of this health care strategy.

OBJECTIVE

Get to know and analyze mental health care in the Family Health Care Program of Maringá, through the opinions of nurses, community agents, psychiatric patients and their relatives.

METHODOLOGY

Study context

Maringá is a city with 288,465 inhabitants located in the Northwest of Paraná State, Brazil. The city constitutes the 15th Regional Health Center, including 30 cities, which is fully managed by the SUS – Single Health System. The municipal network consists of 20 Health Units (HU), one Mixed Unit, one Emergency Unit (24 hours) and the Municipal Hospital. Fifty-seven FHP teams are active in Maringá.

Subjects

In the 20 Health Units, 18 FHP nurses accepted to participate in this study. The 78 community agents who participated were members of these 18 nurses' teams. The same nurses indicated 17 mental patients and 29 relatives, totaling 142 subjects.

Instruments

We constructed an instrument with 25 affirmative statements that focused on the care and guidance offered by the FHP teams, as well as on the benefits of this care.

This Likert-type instrument was called the Opinion Scale on Mental Health Care in the FHP (EOASM/PSF), in accordance with studies on psychometric scales and questionnaires. Five options were offered for each statement: Yes, Frequently, Sometimes, Rarely and No.

The introduction to the EOASM/PSF instrument contains questions to identify the subject and contextual information about mental illness.

Ethical Aspects

The project was approved by the ethics committee (COPEP). Each subject was duly informed, agreed to participate and signed the consent term.

Data Collection

Nurses and agents who agreed to participate were interviewed and answered the tests in the presence of the researchers.

Agents were asked to indicate a mental patient with typical behavior (anxiety, depression, aggressiveness, incoherence, strange attitudes) and/or taking psychotropic drugs (observing black label), excluding alcohol and drugs users. They also indicated a relative (preferably the caregiver).

At patients' homes, the researchers read out the questions and statements to patients and relatives and filled out the forms.

Analysis Procedures

The Kruskal-Wallis test was used for statistical treatment of data, which allowed the researchers to compare the nurses', agents', patients' and relatives' opinions.

The analysis of differences and weaknesses in mental health care delivered by the FHP teams was theoretically supported by literature about the Family Health Program and Psychiatric Reform, as well as by knowledge on Psychiatric Nursing and Mental Health.

RESULTS AND DISCUSSION

Study participants were 18 nurses, 78 community agents, 17 psychiatric patients and 29 relatives of patients, totaling 142 subjects.

The 18 nurses were between 25 and 47 years old and most of them (72%) were graduated from Maringá State University. Community health agents (78) were between 20 and 56 years old. Only two of them possessed a higher education degree and 34 had finished secondary education. Relatives' ages ranged from 20 to 74 years. They were mostly women (83%) and their education level varied between illiteracy (31%) and higher education (6%). The 17 patients were between 21 and 70 years old. Nine of them were women and only three had continued studying after basic education.

General test results

Total scores for each group revealed greater difference between agents' answers and other groups, with relatives and nurses obtaining practically the same scores. Nurses' answers showed less deviation, that is, greater homogeneity among answers, while patients' answers revealed greater variability (Table 1).

Table 1 – Mean total scores and standard deviations of 4 subject groups

Subjects	Mean	Standard Deviation
Nurse	66,1	10,8
Agent	56,9	13,3
Relative	66,4	14,7
Patient	64,8	15,3

The Kruskal-Wallis test for independent group comparisons produced a Chi-square value of 13.64. With 3 degrees of freedom, the probability that equal or higher values would occur corresponded to 0.0034, concluding that scores varied significantly among the groups.

Agents stood out in comparison with other groups. Nurses' answers revealed greater homogeneity, probably due to the specific formation they are submitted to at undergraduate level. Greater dispersion was found among patients, perhaps due to disease symptoms.

In view of these results ($p<0.0034$), which indicate significant variations in scores among different groups, researchers decided to analyze each subject group's answers separately.

Comparative Analysis of Answers per Subject Group

The sums and frequencies of each group's answers to the 5 options (Yes, Frequently, Sometimes, Rarely and No) were analyzed for each of the 25 statements. Next, the most significant differences are highlighted, based on literature.

- Care requested from FHP team

Most professionals mentioned they attended the clients. In turn, clients indicated they received care when they needed the FHP teams' help.

At the Basic Health Units, we observed clients' free access when they requested care from these teams. Their requests were readily attended to, which reveals the accessibility of the FHP, as expected.

- Orientation on medication effects

Nurses have numerous responsibilities in care delivery to clients taking psychotropic drugs. The use of this kind of medication has radically changed mental illness treatment, both in and outside the hospital context[5]. This allowed some family members to maintain their relatives at home. Moreover, mentally-ill patients were able to recover their jobs and productive life in the community.

When patients start psychotropic drugs treatment, nurses are responsible for monitoring their physiological responses and other reactions. Hence, they have to master knowledge about indications for using this medication and desired effects, collateral effects, adverse or toxic effects and contraindications. They also have to know about adequate behavior and care needed for each case.

It is important for nurses to help patients to perceive themselves as active participants in this process, assuming the responsibility to accomplish treatment.

Table 2 – Answers about orientations related to the effects of psychiatric drugs per subject group

Medication effects	Nurse		Agent		Relative		Patient	
	N	%	N	%	N	%	N	%
Yes	4	22,2	22	28,6	3	10,3	1	6,7
Frequently	1	5,6	8	10,4	-	-	1	6,7
Sometimes	8	44,4	8	10,4	2	6,9	-	-
Rarely	3	16,7	3	3,9	-	-	-	-
No	2	11,1	36	46,8	24	82,8	13	86,7
Total	**18**	**100,0**	**77**	**100,0**	**29**	**100,0**	**15**	**100,0**

No answer = Agent 1, Patient 2

Table 2 shows that relatives, patients and agents indicated that they did not agree with the statement about receiving orientations on drugs effects. This is a strong sign that agents are not prepared to provide this kind of clarifications and that clients are not receiving guidance about psychiatric medication use by FHP teams. Nurses and physicians are some of the professionals prepared to offer this care. All teams interviewed in this study included a nurse, but not all of them included a physician. Some nurses (8 out of 18 interviewees) answered that, sometimes, they provide information about the expected and collateral effects of psychiatric medication.

- Clarifications to relatives of mental patients

Most of the FHP clients answered that they did not receive clarifications about living with mental illness. Answers revealed disparities. Few nurses indicated that they offer guidance always (11.1%) or frequently (27.8%). These rates increased to 50% among agents. This deficiency in care is perceived by relatives (72.4%), as shown in Table 3.

Table 3 – Answers about FHP team orientations to relatives per subject group

Orientations to relatives	Nurse		Agent		Relative		Patient	
	N	%	N	%	N	%	N	%
Yes	2	11,1	33	42,3	5	17,2	5	31,3
Frequently	5	27,8	6	7,7	2	6,9	-	-
Sometimes	4	22,2	19	24,4	-	-	1	6,3
Rarely	6	33,3	4	5,1	1	3,5	-	-
No	1	5,6	16	20,5	21	72,4	10	62,5
Total	**18**	**100,0**	**78**	**100,0**	**29**	**100,0**	**16**	**100,0**

No answer = Patient 1

The few clarifications that were given have not been important to promote changes in relatives' behaviors in terms of better living with mental patients. In the same way, little is the increase they have brought about in the patients' sense of responsibility

and active participation. Literature mentions the continuation of high (medication and psychotherapy) treatment abandonment and rehospitalization rates[6-7].

- Treatment concept for mental health - hospitalization

Psychiatric hospitals still exists to absorb a population of non-citizens, using techniques that "should" lead to health recovery and socialization. Moreover, they serve to protect society and safeguard unproductive persons.

In our environment, the open door of the psychiatric hospital is not aimless. This happens because, the higher the number of patients, the greater the quantity of daily allowances (hospitalization authorizations - AIHs). This entails higher profits for the institution and for certain professionals, whose remuneration still depends on the number of patients they attend. This system structure impairs reformist intentions and access to hospitalization services by patients with acute manifestations of illness.

In Brazil, even before Law No 10.216/2001, the deinstitutionalization of mental patients was already under discussion. Not constructing hospitals and decreasing the number of psychiatric beds means choosing other forms of treatment for the mentally ill. Thus, the aim of hospitalization becomes specialized, specific and short-term treatment[8].

The deconstruction of mental institution infrastructure and of ways of thinking and acting in psychiatry suggest the construction of ideas and innovations in mental health care. They also suggest the deconstruction of the internal mental institution infrastructure, that is, what is inside each professional, like in the case of nurses who learned to take care of mental patients only inside closed institutions[9].

In view of determinations by the Ministry of Health to attend mental patients not only in sanatoria, but also in CAPS, outpatient clinics and general hospitals, the researchers expected interviewees to indicate that treatment of mental illness cannot be restricted to hospitalization. However, results showed that about 70% of nurses still do not have a clear opinion on the importance of other treatments.

Alternative community services to substitute for hospitalization, although essential for the dehospitalization process and to legitimize the deinstitutionalization model, are slowly becoming a reality. Cases of revolving doors, in which patients are discharged but successively rehospitalized in the same or in other hospitals still exist, as well as a lack of preparation for patients, families and health professionals.

- The FHP facilitates appointment scheduling

Although group answers varied, most agents (60.9%), relatives (75%) and patients (70.6%) agreed that the implantation of the Family Health Program facilitated appointment scheduling at Basic Health Units. On the other hand, only 44.4% of nurses agreed with this statement. Some relatives confirmed a significant improvement in this respect, as they no longer had to go to the Basic Health Unit early in the morning to schedule an appointment. This aspect has been considered as one of the most visible effects of FHP implantation in Maringá.

- The need for hospitalization and its relation with the FHP

Clients were accustomed to hospitalizations in case of episodes of mental disease and other situations of disturbance or aggressiveness. In other words, the door of the psychiatric hospital was always open for hospitalization. As a result of Decree 224/92, the number of beds and hospitalization times have been gradually decreasing. This condition is reflected by the answers shown in Table 4. This kind of resolutions gained strength when Law No 10.216/2001 was approved, which proposes a gradual decrease in beds and the creation of other treatment alternatives, stimulating judicious hospitalizations.

Table 4 – Answers about other help resources in the FHP per subject group

Help Resources	Nurse		Agent		Relative		Patient	
	N	%	N	%	N	%	N	%
Yes	3	16,7	38	52,8	6	20,7	3	18,8
Frequently	2	11,1	2	2,8	1	3,4	-	-
Sometimes	5	27,8	12	16,7	3	10,3	-	-
Rarely	2	11,1	2	2,8	-	-	-	-
No	6	33,3	18	25,0	19	65,5	13	81,3
Total	**18**	**100,0**	**72**	**100,0**	**29**	**100,0**	**16**	**100,0**

No answer = Agent 6, Patient 1

As to the number of hospitalizations, 43.8% of nurses affirmed that there was no decrease, 40.6% of agents indicated an actual decrease and the same quantity said that there was no decrease. Mental patients and family members confirmed a reduction in hospitalizations (88.9% and 73.7%, respectively). The researchers question whether this difference in opinions is a sign of professionals' lack of knowledge.

Legislation on mental disorder treatments is going through great transformations, which are slowly introduced in Brazil. This has given rise to a 25% decrease in the number of psychiatric hospitals since 1981[10].

The reduction in the number of psychiatric beds points towards the need to consolidate a new interdisciplinary approach in mental health care. State and Municipal Mental Health Coordination Units are implanting this kind of approach at the NAPS, CAPS and outpatient clinics created in the Single Health System (SUS), proposing the progressive substitution of treatment in mental institutions by more effective alternatives at a lower social cost.

Another frequent strategy is the inclusion of beds in general hospitals and the creation of day hospitals, besides emergency services integrated in the health system in different places across the country.

Progressive resocialization programs are being offered to chronic patients who cannot return to their families of origin, with different options, including shelters and protected pensions[11].

Psychiatric hospitalization is restricted to serious cases, needing temporary commitment and intense medication intervention for reversion and control. This requires modern and efficient services with specialized teams, convinced of the efficiency ideal to allow individuals to return home as soon as possible and continue participating actively in community life.

- Religious support

Answers reveal a balance between those agreeing and disagreeing with the statement that hospitalization was used as the only resource for mental treatment before the FHP. It should be asked what these other resources include, and whether they could be related to religiosity.

Even in the 21st century, involvement with mysticism persists in treatment of mental patients.

The large number of psychiatric patients seeking religious help in a FHP in a city located in the interior of São Paulo State shows that difficulties to cope with the suffering caused by mental illness, difficulties involving health services, hopes for a miracle solution and the environment in which religious services are offered are part of this picture. In an attempt to rebalance themselves and their group of origin, subjects walk between different domains and powers: medicine and religion[12].

This is a way of transferring responsibilities and finding support in something stronger than human nature. In this sense, health and religious services, through their specific ways of behavior, offer the elements each person needs to respond to his/her anxieties.

Health teams should also pay attention to this fragility, as the search for a miraculous relief of suffering and the presence of mystical deliria can confound instead of help mental patients and their relatives.

- Family overload and need for support and guidance

Even without specifying any type, all groups agreed that mental illness puts an overload on relatives.

Three main types of overload are imposed on the family when they live with a relative who is mentally ill for more than five years: 1) financial overload, 2) overload in family routines and 3) overload taking the form of physical or emotional diseases[1].

Helping relatives to interact and manage daily life with their patient alleviates burdens, facilitates the establishment of a cooperation process, decreases stress factors that activate crisis situations and stimulates the creation of participation possibilities, improving the quality of life of all stakeholders[13].

This is a time to hear stories of suffering, needs, desires possibilities and knowledge about what people expect from professionals and the system. Nowadays, care is needed to avoid psychiatrists from being standardizers, regulators, separators of madness (a role they have played very well since the birth of psychiatry). The “deconstruction” of the concept of madness and treatments is in course[14].

The Family Health Program – FHP (2001) has played an important role in the context of the current health system. It is defined as a strategy that privileges health promotion, protection and recovery for individuals and families, delivering comprehensive and continuous care to newborns as well as elderly people and to healthy and ill persons alike. The focus of care is the family, which is considered in its physical and social environment.

One of the bottlenecks to expand the Program is the idea that primary care is a synonym of simplified technology. However, the program can be amplified, establishing a good level of integration with other programs, including mental health.

Moreover, to consolidate the FHP, various difficulties have to be overcome, including the composition and maintenance of professional teams and the change in reference frameworks. Nevertheless, the main difficulty to be overcome is the substitution of ideas[15].

FINAL CONSIDERATIONS

These results reveal that the main difference in opinions on mental health care in the FHP is between community health agents and the other groups, while nurses and family members obtain very similar scores. Patients' answers demonstrate more variability, while nurses' answers are more homogeneous.

The increased efficacy in making appointments and the almost unanimous opinions about the importance of FHP deserve special attention.

This research evidences incoherence in opinions about professional guidance on medication treatment and how patients with mental disorders use this information.

These results suggest the need for better professional preparation, in view of the importance of the Family Health Program and the psychiatric reform, emphasizing the reality of joint work, which covers the characteristic dynamics of the academic reality as well as the association between relatives of mental patients and family health teams.

REFERENCES

1. Koga M, Furegato ARF. Convivência com a pessoa esquizofrênica: sobrecarga familiar. Ciência, Cuidado e Saúde/ UEM 2002; 1(1):75-9.

2. Furegato ARF, Santos OS, Nievas AF, Silva EC. O fardo e as estratégias da família na convivência com o portador de doença mental. Texto & Contexto Enfermagem 2002; 11(3):51-6.

3. Morgado A, Lima LA. Desinstitucionalização: suas bases e a experiência internacional. J Bras Psiquiatr. 1994; 43(1):19-28.

4. Ministério da Saúde (BR). Fundação Nacional da Saúde. Programa de Saúde da Família: saúde dentro de casa. Brasília (DF): Ministério da Saúde; 1994.

5. Rolim MA. Os cuidados de enfermagem no tratamento farmacológico dos transtornos mentais no Brasil. In: Organização Mundial da Saúde. O Uso Racional de Medicamentos Psiquiátricos. Rio de Janeiro (RJ): OMS; 1997. p. 93-100.

6. Organización Panamericana de la Salud/Organización Mundial de la Salud - OPAS/OMS. Programa de Salud Mental, División de Promoción de Salud. Modelo para la capacitación de la enfermera general en identificación y manejo de los trastornos afectivos. Generalista I; Washington (DC): 1999.

7. Pitta AMF. Qualidade de vida: uma utopia oportuna. Rev Ciên Saúde Coletiva 2000; 5(1):24-7.

8. Ministério da Saúde (BR). Legislação em Saúde Mental: 1990-2004. Portaria GM nº 106. Dispõe sobre serviços residenciais terapêuticos. Brasília (DF): Ministério da Saúde; 2004.

9. Furegato ARF. A conduta humana e a trajetória do ser e fazer da enfermagem psiquiátrica. In: Jorge MSB, Silva MV, Oliveira FB, organizadoras. Saúde Mental: da prática psiquiátrica asilar ao terceiro milênio. São Paulo (SP): Lemos; 2000. p. 93-116.

10. Stingel A, Lengruber V. A interação dos psicofármacos com outras formas de tratamento dos transtornos mentais no Brasil. In: Organização Mundial da Saúde - O Uso Racional de Medicamentos Psiquiátricos. Rio de Janeiro (RJ): OMS; 1997. p. 71-86.

11. Scatena MCM. Reabilitação psicossocial: lares abrigados. In: Contel JBO, organizador VIII Ciclo de Estudos em Saúde Mental. Multidisciplinaridade e reforma - temas, práticas e políticas em saúde mental. Ribeirão Preto (SP): São Francisco; 2000.

12. Danese MCF, Furegato ARF. O usuário de psicofármacos num programa de saúde da família e suas representações sobre os serviços religiosos. Saúde em Debate 2001; 25(58):70-6.

13. Melman J. Família e doença mental: repensando a relação entre profissionais de saúde e familiares. São Paulo (SP): Escrituras; 2001.

14. Basaglia F, coordenador. A instituição negada: relato de um hospital psiquiátrico. Rio de Janeiro (RJ): Graal; 1985.

15. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): UNESCO/Ministério da Saúde; 2002.

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